

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38349**
Registrar's No. **9342**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 2119		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1803 CORA			d. STREET ADDRESS (If rural, give location) 1803 CORA		
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) L c. (Last) Calhoun		4. DATE OF DEATH (Month) (Day) (Year) 10-21-50			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH Nov. 25, 1891		9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	
11. BIRTHPLACE (State or foreign country) Greenville S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Henry Calhoun	
13b. MOTHER'S MAIDEN NAME Belle		14. NAME OF HUSBAND OR WIFE Cornelia Calhoun		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Cornelia Calhoun		ADDRESS 1803 Cora	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis with INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial infarction DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:45 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE Cathleen E. Taylor		(Degree or title) _____		23b. ADDRESS 1300. Clark	
23c. DATE SIGNED 11.3.50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-6-50	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		DATE REC'D BY LOCAL REG. NOV 3 1950	
REGISTRAR'S SIGNATURE J. B. Sasser		FUNERAL DIRECTOR'S SIGNATURE W. H. Beal		ADDRESS Und. Co. 4303 Delmar	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

Leroy W. Bannister

Licensed Embalmer No. 4523

P. O. Address 3880 Epston Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.